STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125009	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maluhia	1027 Hala Drive Honolulu, HI 96817

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43414 Based on observation, interview, and record review, the facility failed to ensure a resident was free from physical restraints imposed for the purpose of convenience that was not required to treat the resident's medical condition for one of one resident sampled (Resident (R) 68). R68's reclined Geri-chair was not assessed as a restraint, although R68 forgets his physical limitations in standing and walking, R68 was observed to move his Geri-chair or attempt to get up and staff expressed they were unable to provide the constant supervision to prevent falls. Findings include: R68 was admitted to the facility on [DATE] with diagnoses, not limited to, Alzheimer's disease, dementia, weakness, and hemiplegia affecting right dominate side. On 06/30/24 at 09:34 AM to 10:12 AM, observed R68 in the hallway in a reclined Geri-chair. His upper body and head were tensed up not touching the reclined back of the chair, his left hand was holding the hallway rail, legs were reclined up and positioned toward the left side of the chair. Using his left arm, R68 was observed to swivel his chair back and forth in attempts to move it or sit up, while his left leg was moving off and hanging off the chair. R68 yelled and attempted to signal with his arm for unidentified people but no direct care staff were found in the hallway. At 10:12 AM, after surveyor signaled a staff member for R68, the staff member brought the resident closer to the Nurse's station and then where resident was attempting to signal the staff member where he wanted to go, closer to the activities room. During further observations of R68 on 06/30/24 and 07/01/24, in reclined Geri-chair, observed R68 sitting back comfortably in chair with legs reclined up and positioned toward the left side of the chair, not hanging off the chair. R68 was not attempting to move the chair or position himself upright. On 07/02/24 at 12:33 PM, observed R68 in the hallway in reclined Geri-chair with his right side closest to the hallway rail. R68's back of the chair was slightly reclined from a 90-degree angle and legs were reclined up and positioned toward the left side of the chair. R68 was moving his legs side to side, off the chair to back on the chair with slight forward rocking movement while making moaning noises. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/02/24 at 12:37 PM, an interview and concurrent observation with Certified Nurse Aide (CNA) 12 was done. CNA12 reported R68 can sit in his chair with legs slight reclined down but is more comfortable with his chair reclined up. CNA12 demonstrated by lowering the reclined position, during this R68 was rocking forward in a position to try to get out of chair. CNA12 reclined his legs back up and assisted another resident. On 07/02/24 at 12:43 PM, an interview and concurrent observation with CNA33 was done. CNA33 reported R68 likes to have his legs reclined up and if lowered down he may fall because he wants to walk but is unable to. CNA33 reported that they cannot watch him all the time because they need to help other residents. CNA33 lowered his legs down and R68 was observed to scoot himself towards the edge of the chair with slight rocking movement forward in a position to get out of the chair. CNA33 stayed by his side and redirected and repositioned him so he does not fall. CNA33 requested assistance from other staff members to bring R68 to his room. On 07/02/24 at 12:54 PM, an interview with Head Nurse (HN) 9 was done. Inquired with HN9 if the facility did a restraint assessment for R68's Geri-chair. HN9 reviewed the Electronic Health Record (EHR) and reported a restraint assessment was not done for the Geri-chair. HN9 further reported the Geri-chair would be considered a restraint if the resident is trying to get up on their own and it is restraining their movement. HN9 stated the Geri-chair is not a restraint for R68 because he does not have the ability to walk. HN9 confirmed that although R68 does not have the ability to walk he tries to get up and stand and is not aware of his limitations. On 07/02/24 at 01:56 PM, an interview with R68's resident representative (RR) 52 was done. RR52 reported R68 suffered a stroke and lost control of his right side of his body. R68 thinks he can get up and stand but has fallen from his bed a few times at the facility. The facility now puts him in a Geri-chair when he is restless and to give more social interaction. Review of the facility's event report for R68's falls on 02/21/24 and 05/17/24 was done. On 02/21/24, R68 was found on the floor in room next to his bed, documentation from staff members reports documented resident verbalized wanting to go home as a factor influencing the incident and to prevent the incident from happening again, place resident in recliner in a visible area for close supervision, if attempting to get up from bed. On 05/17/24, R68 was found on the floor next to his bed, documentation from staff members reported resident was restless. On 07/03/24 at 10:12 AM, an interview with Director of Nursing (DON) was done. DON stated she looked at R68 the other day and found him to be restless and uncomfortable. Inquired what is the facility's process in identifying possible physical restraints and devices, DON reported the facility would assess if there were a need for safety then get an order. The facility wanted R68 to get out of bed and use the Geri-chair for comfort and felt it was better to sit on for his safety because they do not want R68 to fall. DON further mentioned in the interview that the facility does not have the staffing for one-on-one supervision. Concurrent review of R68's INFORMED CONSENT FOR USE OF PHYSICAL RESTRAINTS signed and dated 01/14/24 mention Geri-chair as a type of restrained to be used. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure PHYSICAL RESTRAINTS AND DEVICES effective 09/08/06, documents Restraints are to be used only when necessary under limited medical conditions or symptoms to prevent injury to resident and/or others .Restraints must not be applied for the purposes of discipline or staff convenience. Restraints must be ordered by the attending physician for a specified and limited period of time .Physical restraints include, but are not limited to .Geri chairs .A THREE-DAY ASSESSMENT PERIOD shall be implemented upon admission or use of new device to determine if the resident required the device to ensure resident's safety, increase function and/or to complete a medical treatment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on record review and interview the facility staff failed to correctly document Resident (R) 6's facility acquired injury, progressing from Moisture-Associated Skin Damage (MASD) on his right gluteus to a stage 3 Pressure Ulcer (PU) on his coccyx, in R6's Discharge Assessment that was submitted to Center of Medicare and Medicaid Services (CMS) on 05/27/24. The deficient practice does not accurately reflect R6's injured skin status. The deficient practice could affect all residents who have an injury that has worsened over time. Findings Include: Cross-reference to F842 Resident Records - Identifiable Information. Based on record review and interview the facility failed to update R6's electronic health record (EHR) to accurately stage his facility acquired injury progressing from Moisture-Associated Skin Damage (MASD) to his right gluteus to a stage 3 PU on his coccyx. On 07/01/24 at 01:45 PM interviewed Minimum Data Set (MDS) coordinator 1 and inquired who stages the resident's skin injuries and she stated the nurses on the unit determine the type or stage of the injury. On 07/03/24 at 11:04 AM interviewed Head Nurse (HN) 9 on second floor. Inquired about R6's MASD and stated that it appears to be a PU. HN9 stated it is a stage 3 PU. HN9 explained R6's Nurse Practitioner, an outside provider, had identified the injury as a stage 3 PU in her documentation which was provided to the facility. HN9 stated the team met on 07/02/24 to discuss R6's injury and agreed the MASD had progressed to a stage 3 PU. At this time requested HN9 provide copies of R6's Care Plan (CP), doctor's orders, skin assessments, progress notes and NP Assessment. On 07/03/24 at 11:16 AM met with and interviewed DON who stated there was a meeting yesterday (07/02/24) and the team discussed R6's injury and concur it is no longer MASD but a stage 3 PU and the change should have been made in R6's EHR. On 07/03/24 review of R6's CP, doctor's orders, weekly skin assessments and weekly progress notes has documentation of R6's injury as MASD. During this review there was no documentation found that facility staff documented R6's PU progressed (got worse) from the MASD to a stage 3 PU on his coccyx with full thickness skin loss as documented by R6's NP on 05/14/24. During this review noted NP assessment had been faxed to the facility on [DATE] at 02:14 PM. NP documented on R6's injury Started as MASD but worsened with pressure. Review of R6's MDS found he had a Discharge Assessment that was submitted to CMS on 05/27/24, section M did not include R6 had an unhealed pressure ulcer (s) at Stage 1 or higher. No was checked off for this question. Other problem checked off included H. Moisture Associated Skin Damage (MASD).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43414 Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan for one of 19 residents sampled (Resident (R) 68). R68's care plan did not include reclined Geri-chair in visible area for close supervision as an intervention to prevent R68 from falls when restless and expressing he wants to go home. Findings include: Cross Reference to F604. The facility failed to ensure a resident was free from physical restraints imposed for the purpose of convenience that was not required to treat the resident's medical condition for one of one resident sampled (Resident (R) 68). R68's reclined Geri-chair was not assessed as a restraint, although R68 forgets his physical limitations in standing and walking, R68 was observed to move his Geri-chair or attempt to get up and staff expressed they were unable to provide the constant supervision to prevent falls. On 07/02/24 at 01:56 PM, an interview with R68's resident representative (RR) 52 was done. RR52 reported R68 suffered a stroke and lost control of his right side of his body. R68 thinks he can get up and stand but has fallen from his bed a few times at the facility. The facility now puts him in a Geri-chair when he is restless and to give more social interaction. Review of the facility's event report for R68's falls on 02/21/24 and 05/17/24 was done. On 02/21/24, R68 was found on the floor in room next to his bed, documentation from staff members reports documented resident verbalized wanting to go home as a factor influencing the incident and to prevent the incident from happening again, place resident in recliner in a visible are for close supervision, if attempting to get up from bed. On 05/17/24, R68 was found on the floor next to his bed, documentation from staff members reported resident was restless. On 07/03/24 at 10:12 AM, an interview and concurrent record review with Director of Nursing (DON) was done. Inquired if R68's care plan included the Geri-chair, DON confirmed the Geri-chair was not care planned.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48351 Based on interviews and record review, the facility failed to invite one of the sampled residents (Resident (R) 76) to attend and participate in her care planning meeting. This deficient practice has the potential to affect all the residents in the facility. Findings Include: R76 is a [AGE] year-old female admitted to the facility on [DATE]. A review of R76's Brief Interview for Mental Status (BIMS) with Assessment Reference Date (ARD) 04/17/24 was conducted. R76's BIMS score was a 14, meaning R76 was cognitively intact. Interview with R76 was conducted in her room on 07/01/24 at 09:28 AM. R76 stated that she had not participated in her care planning meeting, and she would have loved to go. R76 stated, I've never heard of them having a meeting about me. If someone told me, I would have remembered and I would go. A review of R76's Electronic Health Record (EHR) was conducted. The record noted a care plan meeting held on 04/24/24. R76's son was listed as an attendee. R76 was not on the list for attendees. Interview was conducted over the phone with the Social Worker (SW) 2 on 07/03/24 at 09:04 AM. SW2 stated that she does not recall inviting R76 to her care planning meeting. A review of the facility document titled, Comprehensive Care Plan Guideline, was conducted. The document noted, The resident and/or representative will be invited to attend the interdisciplinary Care Plan meeting during the Admission, Quarterly, Annual, and/or Significant Change Care Plan review meetings and upon request.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43414 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Findings include: On 06/30/24 at 08:42 AM, during an initial tour of the kitchen with [NAME] (C) 1, observed an opened and used large container of French salad dressing in the refrigerator. The salad dressing did not have an open/preparation date and a use-by-date. C1 was observed to immediately take the salad dressing out of the refrigerator and confirmed there should be a label for when the dressing was opened and when it should be discarded. Observed in a plastic container bin with a bag of oatmeal, a scooper on the bottom of the bin with oatmeal residue and unidentified debris. C1 confirmed the scooper should be hung and not touching the bottom of the bin. At 09:19 AM, observed C2 answer the phone, hang up the phone, put gloves on, and then his mask, before going back to prepping food, without washing his hands. Inquired with C2 if he washed his hands before putting on his gloves, C2 stated he did not. On 07/02/24 at 03:00 PM, an interview with Dietician (D) 3 was done. D3 reported staff should wash their hands prior to prepping food when touching other items to prevent foodborne illnesses. Review of the facility's policy and procedure Food Preparation and Handling effective 09/01/10, documented All food items, while bring prepared, are protected against contamination from dust, flies, rodents and other vermin unclean utensils and work surfaces, unnecessary handling, coughs, sneezes .and any other source of contamination .Foods will be prepared and served with clean tongs, scoops, forks .plastic gloves or other suitable implements to minimize handling and avoid manual contact of food at all point during preparation and service. Review of the facility's policy and procedure Hand Hygiene effective 02/03/23, documented Indications for Hand Hygiene .Before preparing or serving food .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37954 Based on record review and interview the facility failed to update Resident (R) 6's electronic health record (EHR) to accurately stage his facility acquired injury progressing from Moisture-Associated Skin Damage (MASD) on his right gluteus to a stage 3 Pressure Ulcer (PU) on his coccyx. This deficient practice could affect all residents who have skin injuries that are not being documented correctly. Findings Include: On 07/01/24 at 10:09 AM during record review of R6's EHR found he had a newly in-house (facility) acquired MASD injury documented on his skin assessment dated [DATE]. Weekly skin assessments for R6 were filled out from 03/19/24 - 06/19/24 documenting R6 had MASD on his Right Gluteus that at times was deteriorating, stalled or improving. Weekly progress notes for Skin/Wound Notes, written by facility Registered Nurses (RNs), dated from 03/16/24 - 06/26/24 also had documentation that R6 had MASD and not a stage 3 PU to his coccyx. Review of pictures provided in R6's EHR showed R6's injury was deeper than superficial. On 07/01/24 at 01:45 PM interviewed Minimum Data Set (MDS) coordinator 1 and inquired who stages the resident's skin injuries and she stated the nurses on the unit determine the type or stage of the injury. On 07/03/24 at 11:04 AM interviewed Head Nurse (HN) 9 on second floor. Inquired about R6's MASD and stated that it appears to be a PU. HN9 stated it is a stage 3 PU. HN9 explained Point Click Care (EHR software) does not give the facility an option to change the documentation from progression of MASD to a PU. HN9 explained the MASD would have to be resolved and then the PU put into the EHR. HN9 explained R6's NP, an outside provider, had identified the injury as a stage 3PU in her documentation which was provided to the facility. HN9 stated the team met on 07/02/24 to discuss R6's injury and agreed the MASD had progressed to a stage 3 PU. At this time requested HN9 provide copies of R6's Care Plan (CP), doctor's orders, skin assessments, progress notes and NP Assessment. On 07/03/24 at 11:16 AM met with and interviewed DON who stated there was a meeting yesterday (07/02/24) and the team discussed R6's injury and concur it is no longer MASD but a stage 3 PU and the change should have been made in R6's EHR. On 07/03/24 review of R6's CP, doctor's orders, weekly skin assessments and weekly progress notes has documention of R6's injury as MASD. During this review there was no documentation found that facility staff documented R6's PU progressed (got worse) from the MASD to a stage 3 PU on his coccyx with full thickness skin loss as documented by R6's Nurse Practioner (NP) on 05/14/24. During this review noted NP assessment had been faxed to the facility on [DATE] at 02:14 PM. NP documented on R6's injury Started as MASD but worsened with pressure.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48351 Based on observations, interviews, and policy review, the facility failed to ensure proper hand hygiene procedures were followed by a staff member during medication administration. This deficient practice promotes the development and transmission of communicable diseases and infections. The deficient practice has the potential to affect all the residents in the facility. Findings Include: Concurrent observation and interview were conducted on 07/02/24 at 08:16 AM. Registered Nurse (RN) 10 was observed preparing medications for Resident (R) 8. After placing the pills in the cup, RN10 walked to the refrigerator for apple juice. RN10 could not find apple juice so he/she used the telephone to call the facility kitchen. RN10 then walked back to the medication cart and poured laxative powder into a cup. RN10 then walked back to the refrigerator and grabbed cranberry juice to add to the laxative powder. After mixing the laxative and cranberry juice, RN10 entered R8's room. RN10 then proceeded to administer whole pills to R8, followed by the laxative and cranberry drink. RN10 was not observed performing hand hygiene throughout the different tasks. RN10 was asked if he/she should have performed hand hygiene prior to R8's medication administration. RN10 stated hand hygiene should have been done prior to giving R8 her medications. Interview was conducted with the Director of Nursing (DON) on 07/02/24 at 01:50 PM. DON confirmed that RN10 should have performed hand hygiene prior to administering medications to R8. A review of the facility policy titled, Hand Hygiene, dated 08/01/10, was conducted. The document noted, Indications for Hand Hygiene (Alcohol Based Hand Rub or Handwashing) .Before administering mediations.